ATTACHMENT 1:
SUMMARIES OF DRAFT OPTIONS PAPERS FOR HEALTH REFORM

The following summaries are taken from drafts submitted by grantees (in alphabetical order of the lead authors) under the Health Care Options Project to the California Health and Human Services Agency in October 2001. These drafts are subject to change in the final papers, and many important details are not included in the summaries, including those describing the target levels for subsidies, the benefits that would be offered and program administration, because the authors are still refining their proposals.

E. Richard Brown, PhD, UCLA Center for Health Policy Research and UCLA School of Public Health,
Richard Kronick, PhD Department of Family and Preventive Medicine UCSD School of Medicine

STEPPING UP TO UNIVERSAL COVERAGE: A Proposal for Health Care Reform in California

The lack of health insurance for more than 6.3 million California residents underscores the need for universal coverage. But the lack of universal coverage creates problems for other constituencies as well. Hospital trauma centers and emergency rooms — the only source of needed medical services for many uninsured residents — are overwhelmed with uncompensated care; their continuing red ink and dwindling numbers deprive all Californians of this increasingly critical component of our health system.[i] In the absence of provisions to ensure universal coverage, private health insurance plans and public programs alike experience churning enrollments, creating uncertainty that makes it difficult to manage risk and make long-term investments in the health of enrollees.[ii] The resulting chaotic market conditions contribute to insolvency of health plans, threaten safety net providers of care, and drive some health professionals from practice. And just when we saw progress in rising rates of employment-based health insurance coverage, escalating costs and growing unemployment are once again threatening to expand the ranks of the uninsured.[iii]

We propose a mixed public-private financing system to achieve universal coverage through a two-stage process. With full implementation, this combined approach will cover all citizens and legal immigrants residing in California. Many Californians will continue to obtain employer-sponsored coverage as they do now, but all legal residents in California will be able to obtain publicly sponsored coverage through Healthy California, a program built on the foundation of Healthy Families and Medi-Cal. The proposed reform is summarized here and described in more detail below.

We propose to achieve universal coverage in two stages. In the first stage, to be implemented soon after enactment and lasting for three years, Medi-Cal and Healthy Families will be integrated into a new program called "Healthy California." Healthy California will include all persons currently eligible for Medi-Cal through the children and families program, for Healthy Families, and for some other programs; in addition, after a federal section 1115 waiver is obtained, it will include adults without children who have family incomes that do not exceed 150% of poverty. A state standard for benefit packages (SSBP), approximating the Healthy Families benefits (the benchmark), will be established. The administrative capabilities for the full expansion of Healthy California in stage two will also be created during this first stage.

In the second stage, implemented three years after enactment, enrollment in Healthy California will be opened to all legal residents in the state, and a "pay-or-play" premium requirement will be implemented. In order to cover all eligible persons, coverage through Healthy California will be available without premium payment at the time of enrollment. Employers and employees will each pay a percentage of payroll for any

employee or employee's dependent who is not covered by employer-sponsored insurance, Medicare, or CHAMPUS. Self-employed persons will pay a similar income-adjusted premium. The pay-or-play premium payment will finance coverage under Healthy California and encourage the continuation of employer-sponsored coverage for those who are currently satisfied with this arrangement. The first and second stages will be financed, in part, by maximizing federal matching funds for Medi-Cal and Healthy Families.

---

[i] Jennifer Warren, "State Urged to Intervene in Hospitals' Urgent Care: Emergency rooms are closing because of financial losses," *Los Angeles Times*, Jan. 18, 2001; and [Editorial], "Wounded Trauma Centers," *Los Angeles Times,* June 13, 2001.

[ii] Lawrence Casalino, "Canaries in a Coal Mine: California Physician Groups and Competition," *Health Affairs*, 2001; 20 (4): 97-108; and James C. Robinson, "Physician Organization In California: Crisis And Opportunity," *Health Affairs*, 2001; 20 (4): 81-96.

[iii] Jon Gabel, Larry Levitt, Jeremy Pickreign, et al., "Job-Based Health Insurance In 2001: Inflation Hits Double Digits, Managed Care Retreats," *Health Affairs*, 2001; 20 (5): 180-186; Todd Gilmer and Richard Kronick, "The Calm Before the Storm: Expected Increases in the Number of Uninsured," *Health Affairs*, 2001, November/December.

Bob Brownstein, Sarah Zimmerman, Louise Auerhahn, Sarah Muller, Michael Elliott, Wei Kuan Lum, Working Partnerships USA

THE MANAGED CARE EXPANSION PROGRAM

The long-term objective of the Managed Care Expansion Plan (MCEP) is to provide affordable health insurance to all California citizens with incomes equal to, or under, 400% of the Federal Poverty Level (FPL). In attempting to achieve this objective, the plan employs a number of strategic judgments.

1) To a great extent, the plan relies on the expansion of existing health insurance institutions and health care delivery systems rather than establishing totally new models. This approach is based on the view that both fiscal and political considerations make a large scale, rapid and fundamental change in health insurance options unlikely. In the alternative, an incremental approach may prove to be more feasible, offering less risk, engendering less resistance, and requiring less immediate cost. An incremental model can be most effectively designed if it is based on some subset of existing structures.

2) Within the existing health insurance framework, the plan has selected two components on which it seeks to build for an expanded program. The first of these is a reliance on public sector institutions. As will be noted below, a focus on public sector insurers offers advantages in terms of reliability and quality of services and economies of scale. Secondly, with the exception of rural areas, the plan relies on managed care, with the intent of encouraging the best of that approach in terms of an emphasis on preventive care, avoidance of unnecessary procedures, and reasonable cost controls.

3) At the same time that MCEP seeks to expand health coverage to uninsured California residents, it also attempts to improve the fiscal stability and sustainability of "safety net" institutions in the health care delivery system. Safety net hospitals and clinics play a critical role in guaranteeing quality care to those California residents who remain uninsured while progress towards universal coverage is slowly accomplished. Essentially, the safety net allows the existing health care delivery system to meet at least minimum levels of access to all persons in need during that extended period over which improvements to coverage can be implemented.

4) The MCEP is a long-term, phased in, strategy. One rationale for this approach is the deliberate intent to present the governor and legislature with a functional way to view the achievement of universal health insurance as a state priority that can compete, over time, with other state priorities, such as transportation and education. From this perspective, the state will have the option of either weighing this priority against others when economic cycles generate additional revenues

or moving more rapidly through tax increases if decision-makers should conclude that an expedited pace of program implementation is desirable.

5) Although state resources are the primary source of funding for expanded health coverage under this model, the plan does require that either insurance recipients or their employers must pay a share of premium costs. Based on current projections of program costs, approximately 29% of the total statewide cost of premiums would be paid by private parties. This approach allows the MCEP to be compatible with innovative efforts to encourage or assist employers to play a greater role in the provision of health insurance to lower income workers.

Peter Harbage, Katie Horton, Jennifer Ryan, HealthPolicyR&D

THE CALIFORNIA PACADVANTAGE PREMIUM PROGRAM (CPPP)

Due to cost and administrative barriers, small businesses find it particularly challenging to provide health care to their employees. In fact, only 48 percent of small businesses in California offer health insurance to their employees, which contributes to the fact that about half of California's uninsured are employees of small businesses and their dependents. To help small businesses to overcome obstacles to coverage, action is needed from both the public and private sectors.

Under this proposal, California's existing non-profit small employer purchasing pool – PacAdvantage – could be coupled with a premium assistance program. To be known as the California PacAdvantage Premium Program (CPPP), this program could subsidize the cost of quality health insurance for small businesses that did not previously offer employer-sponsored group health insurance coverage (ESI) for uninsured employees. CPPP would use existing PacAdvantage procedures and add a subsidy option for certain businesses on top of the program.

CPPP is designed to be a simple, flexible, and supportive means of helping certain small businesses and their low-income employees obtain coverage through the private health insurance market. An increase in tobacco or liquor tax, as well as donations from for-profit and non-profit private entities, could fund a new state Health Insurance Trust Fund designed to provide sliding scale support for participating employers and employees. While the Pacific Business Group on Health would operate the program, California's Managed Risk Medical Insurance Board will oversee the policy issues surrounding CPPP.

To participate, employers must receive an annual certification that they have fulfilled the participation requirements, including that the employer has: 1) 50 or fewer employees for more than 50 percent of the working days during the year; 2) a majority of employees residing in California; and, 3) not offered insurance in the previous 6 months (with certain exceptions).

Employee eligibility, which will be determined annually, is contingent upon several requirements being true at the time of the determination. CPPP is not an entitlement program, and MRMIB will be able to control enrollment in response to changes in financial resources. To be eligible for the subsidy, individuals must: 1) Live in a family where either they or a parent/guardian works for a participating employer 20 hours or more a week; 2) have a family income below 350 percent of the federal poverty level; 3) Be ineligible for Medi-Cal, Medicare, Healthy Families, Access for Infants and Mothers, and Medicare; and not been enrolled in insurance during the previous six months (with certain exceptions). For both employers and employees, other requirements must be met to continue coverage.

Under CPPP, employers must offer a quality health insurance product. To assure this, employers are strongly encouraged to select one of the many products offered through PacAdvantage. Under PacAdvantage, dental, vision, and chiropractic/acupuncture coverage is optional; participation in CPPP requires that the dental and vision riders be provided. In the event that the employer wishes to offer a non-PacAdvantage product, there is an option for doing so. With regard to cost sharing, there are no separate cost-sharing limits beyond the premium already set by PacAdvatange for a given plan.

The maximum subsidy available under the program is 55 percent. This support is available when the individuals covered are below 200 percent of poverty. The subsidy decreases on a sliding scale and phases-out completely for individuals at or above 350 percent of poverty.

James G. Kahn, et al, University of California, San Francisco.

SINGLE PAYER OPTION PROPOSAL

This proposal describes a “single payer” health care reform option, as part of the Health Care Options Project convened by the Department of Health Services, State of California. Proposals for single payer health care reform in California have been debated for more than ten years; a key version was Proposition 186, a statewide ballot initiative in 1994. A primary principle is to provide universal or near-universal health care coverage. The proposed option paper builds on Proposition 186.

The proposed strategy is as follows: “Single payer” incorporates all Californians in a single, publicly-financed health insurance pool. The benefits package is comprehensive. Revenues for the pool derive from current health care spending, earmarked taxes that take the place of current out-of-pocket expenditures, and other sources. The scores of public and private funding streams will be replaced by a single, integrated system with standard reimbursement rates and simplified administrative functions. Savings due to simplified administration and other cost-saving features will finance the increased care for the previously uninsured and under-insured. Spending is limited by global budgets at the state and regional levels and for facilities. Health care is provided, as now, by private physicians, group practices, integrated delivery systems, and the public system. Provider reimbursement is based on negotiated rates (fee-for-service, capitation, and facility global budgets) that are risk-adjusted as appropriate. Administration of the single payer system is by an elected health commission and public state board and regional boards.

In addition to maintaining health care spending at current and projected levels while expanding coverage, other anticipated outcomes include: heightened quality of care through improved data on and analysis of health care outcomes; advances in public health and innovative technologies; and improved responsiveness to public concerns.

Helen Schauffler, with significant contributions from: Sylvia Guendelman, Joyce Lashof, Sharon Levine, Sara McMenamin, Patricia Powers, and Sara Singer,
University of California at Berkeley, Center for Health and Public Policy Studies

THE CHOICE PROGRAM

The CHOICE Program will reform California's health care system through the voluntary actions of working adults based on their preferences and economic incentives. All non-elderly California workers and their non-working dependents who elect to enroll in CHOICE will have two major options for affordable, comprehensive health insurance coverage:

1) to get their medical care from any licensed health care professional or facility that participates in the statewide CHOICE Network for provision of covered services. Providers may elect to participate in the CHOICE network or not.
2) to enroll in any state licensed group model HMO, County Organized Health System (COHS), or Local Initiative (LI) plan that contracts with the CHOICE Program. Eligible health plans may elect to participate in CHOICE or not.

MRMIB will administer the CHOICE Program. Existing sources of financing include state funds for the MRMIP and AIM programs; the State's share-of-cost for workers eligible for the Medi-Cal Program; the State and Federal share-of-cost for persons eligible for Healthy Families; savings in the State's direct subsidies for indigent care resulting from coverage of persons previously indigent and uninsured; continued State funding of indigent care programs for the uninsured; and the State's General Fund, as necessary. New sources of financing include a wage-based worker monthly premium, a quarterly employer payroll tax, and funding from the proposed NAFTA Social Integration Fund for Mexican citizens working in California.

The CHOICE Program involves no state mandates of individuals or employers, no new Federal waivers, no additional Federal funding, and no ERISA waiver. Rather, it restructures current payment mechanisms to cover more than 6 million currently uninsured Californians.

Helen Schauffler, University of California at Berkeley, Center for Health and Public Policy Studies

CAL-HEALTH

This Health Care Option proposal, referred to as Cal-Health, is based on Assembly Bill 32 (AB 32), which was introduced by Assembly Member Richman, Senator Figueroa, and Assembly Member Chan on December 4, 2000. The Principal co-author is Assembly Member Thomson, and other co-authors include Assembly Members Aanestad and Koretz, and Senators Burton, McPherson, and Romero. AB 32 passed the Assembly on June 6, 2001 and was referred to the Senate for deliberations.

Existing law provides for creation of various programs to provide health care services to persons with limited incomes and meeting various eligibility requirements. These programs include the Healthy Families Program administered by the Managed Risk Medical Insurance Board (MRMIB) and the Medi-Cal program administered by the State Department of Health Services (DHS). This proposal would create the California Health Care Program (Cal-Health), which will coordinate the Healthy Families program through MRMIB, and the Medi-Cal program through DHS by providing a uniform and simplified application process. This option provides for outreach efforts to increase enrollment in the Healthy Families and Medi-Cal programs for those persons currently eligible but not enrolled. This option seeks to expand health insurance coverage through the Medi-Cal program to all persons who have family incomes at or below 250 percent of the federal poverty level. Additionally, this option seeks to develop standard uniform benefits packages (SUBP) that can be offered by commercial carriers to persons with incomes above 250 percent of poverty and small firms.

Ellen R. Shaffer, PhD, MPH

THE CALIFORNIA HEALTH SERVICE PLAN

This proposal aims to establish a California Health Service, a publicly funded program that will provide universal and comprehensive coverage for all Californians. The program would also transfer responsibility for delivering health care to the public sector. Clinicians and other health care workers would be salaried and paid by the State, which would also sponsor their education and training. The proposal is designed to rebalance the relationships of providers and users of health care services, payers, and the state, in the interests of high quality outcomes from personal health services, and improving population health. The plan addresses delivery system issues in part to manage potential increased demand for services from the state's previously uninsured and underinsured population. It also addresses the unique characteristics of California's large uninsured population, which render impractical expansions of insurance coverage through the workplace. Compared with the nation, uninsured Californians disproportionately encompass working non-citizens, "flex" or contingent workers who do not work full time for a single employer during the year, and individuals earning more than 300% of the federal poverty level as well as low-income adults. The proposal incorporates lessons from the experiences of industrialized nations that provide universal coverage, with particular attention to those that operate a health service system, and builds on existing patterns in California of funding and providing health services. The proposal structures a key role for a focused public health system. Physician education and employment policies would change the balance between primary care and specialty services in a manner that would make the system less costly. To this extent the proposal is designed to redress the limits of market-oriented approaches to controlling costs and expanding coverage, and the inefficiencies in the health care delivery system that have resulted from the emergence of for-profit hospitals, health systems and health insurance plans. The proposal presents major features in the reorganization of a complex system, to establish a rationale for change, and draw links between the present system and its proposed evolution.

Judy Spelman, RN and Health Care for All - California

CAL CARE:
A SINGLE PAYER HEALTH CARE SYSTEM FOR CALIFORNIA

This proposal, "Cal Care", is presented to the state and the people of California by Health Care for All-California. "Cal Care" is a comprehensive reform of health care finance and administration based on a single payer model. Despite our great wealth and years of reform efforts the number of uninsured Californians hovers around seven million, quality of care and health outcome indicators are deficient, physician frustration and nurse shortages are widespread, health care costs are rising and public health and safety net solvency is threatened.

In the "Cal Care" model the state of California replaces all current public and private payers and assumes responsibility for the health of the population. A universal risk pool and a single streamlined administrative system replace hundreds of insurance and safety net pools and bureaucracies. Money saved by restructuring administration is redirected to health care and all medically necessary care is covered. Coordinated, system wide planning for health expenditures and services is initiated and is based on standards of quality and care. The system is funded by current government spending and by a health tax that replaces all premiums, co-pays and deductibles. The delivery of care remains private. Accountability in governance is strengthened.

At this point in our history we believe that a government-led effort has the best chance to achieve a value-driven reform from which all Californians can benefit. This proposal gives full authority to state of California to implement a single payer system founded on the following principles:

- All people are created equal and should have an equal opportunity to achieve their best possible state of health.

- Providing high quality care is as important as providing universal coverage.

- The initiative, creativity and entrepreneurial spirit of the market system must not be lost. It should be revitalized and refocused on health. Public-private partnerships for health will be an integral part of building a single payer system.

- The single payer system should be built on the foundation of existing institutions.

- All must abide by the basic standards of the single payer system, but institutions, providers, consumers and producers will have the freedom to bring the standards to life. Local autonomy will be underscored.

- The goals of the Cal Care single payer system are universal coverage based on California residency, high quality of care system wide, comprehensive and accessible benefits, provider and consumer satisfaction, and public confidence in the system.

Lucien Wulsin, Jr., Peter Long, Roohe Ahmed, Megan Hickey, Jan Frates; Insure the Uninsured Project

HEALTH CARE OPTIONS PROPOSAL

Insure the Uninsured Project proposes that California begin to cover its 6.8 million uninsured through a balanced approach combining both public and private sector initiatives to improve affordability of coverage:

- Refundable targeted refundable tax credit to increase the offer rate for employers with low wage workforces
- Purchasing credit to increase take up rates by low wage workers for family coverage
- Refundable tax credit/voucher and structural reforms to increase coverage of the flex workforce (temporary, part time, seasonal, contract workers and the self employed) who are not typically offered coverage through an employer
- Medicaid §1115 waiver to cover low-income adults and
- Seamless coverage for those enrolled in public programs.

Under our proposal California's lowest income uninsured will be covered by expanding MediCal and Healthy Families; those with higher incomes will have improved access to and better affordability of private coverage.

In combination with California's existing coverage, this would give all California residents who cannot afford health coverage opportunities to secure affordable coverage through their employer, the individual market and/or public programs. It would lay the foundation for universal coverage if California can develop the political consensus for a single payor system or for a combination of individual and employer mandates to achieve universal coverage.

This is not the most cost effective approach for California's government; a combination of individual and employer mandates would be more cost effective for state government. However it is politically and economically feasible and would dramatically increase affordability of coverage.

Our challenge in designing these options is the inefficiency of incremental change in our multilayered, complex, and overlapping public/private system:

- How to cover the uninsured while avoiding paying twice for coverage to those already insured and for care to the uninsured already paid for by government
- How to account for unintended side effects such as crowd out and crowd in of public and private payors based on their changing economic incentives and
- How to reconfigure California's jig saw puzzle of coverage in a sensible fashion; which populations are best covered by expansion of public programs and which are best covered by financial assistance for private coverage.

This proposal addresses key weaknesses in California's system: lack of affordability of private coverage for low wage and flex workforces and the deterrence by complexity of public coverage. It does not change the basic structure of either public or private coverage; that is addressed in other options papers. It seeks to avoid shifts for individuals with existing coverage and suggests a starting point for state health reform efforts to cover the uninsured.